

The Ultimate Care Group Limited - Kensington Court Lifecare

Current Status: 8 April 2013

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Certification Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Kensington Court Lifecare provides residential care for up to 87 residents who require hospital and rest home level care. Occupancy on the day of the audit is at 64. The facility is operated by The Ultimate Care Group Limited. Staffing is stable with minimal turnover. Staff hours are increased if required to meet the needs of residents. Residents and family interviewed provide positive feedback on the care provided. There have been no changes to the facility, staffing structure, management or systems since the last audit.

One area has been rated as continuous improvement (beyond the standard normally expected) relating to a quality initiative implemented to reduce the rate of urinary tract infections in the facility. There are two areas identified that require improvement relating to documentation for activities, and documentation for medicine management.

Audit Summary as at 8 April 2013

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded

Indicator	Description	Definition
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 8 April 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 8 April 2013

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 8 April 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Safe and Appropriate Environment as at 8 April 2013

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 8 April 2013

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 8 April 2013

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Consumer Rights

The facility ensures information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, is accessible and brought to the attention of residents' and their families on admission to the facility. All residents and family members interviewed verify that their rights are met at all times during service delivery, that staff are respectful of their needs, communication is appropriate, and they have a clear understanding of their rights, and the facility's processes if these are not met.

There is verification from residents and family that consent forms are provided prior to admission to ensure they have time for consultation and are fully informed. Time is provided if discussions and explanation is required. An older persons' advocate is available if required and is interviewed during the audit, confirming the facility encourages external support if required.

There is evidence of consideration of residents' personal choices, acknowledging and supporting cultural, spiritual and individual rights and beliefs, and encouraging independence.

The facility manager is responsible for management of complaints and a complaints register is maintained. The residents can use the complaints forms or raise issues at the residents' monthly meetings.

Organisational Management

The Ultimate Care Group Limited is the governing body and is responsible for the service provided at Kensington Court Lifecare. A range of key planning documents were reviewed and include a vision statement and core values. Systems are in place for monitoring the service provided at Kensington Court Lifecare, including regular monthly reporting by the facility manager to The Ultimate Care Group Limited head office.

The facility is managed by a suitably qualified and very experienced facility manager, who is a registered nurse who has been in this current role for the last six years. The facility manager is supported by a clinical services manager, who has been in the current role for two years.

The Ultimate Care Group quality and risk management systems are imbedded at Kensington Court Lifecare. There is evidence that quality improvement data is collected, collated, and analysed to identify trends and corrective actions are implemented to improve service delivery. There is an internal audit programme in place. A range of risks are identified and managed. Adverse events are documented on accident/incident forms and an electronic database is reviewed by personnel from The Ultimate Care Group Limited head office.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, enrolled nurses, the pharmacist, dietician, podiatrist, and general practitioners is occurring. There is evidence available indicating an in-service education programme is provided for staff at least monthly. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the Careforce education modules. Review of staff records provide evidence that human resources processes are followed as required (e.g., reference checking, criminal history vetting, interview processes for appointment and individual education records are maintained).

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum amount of staff is provided during the night shift and consists of one registered nurse and three caregivers. The facility manager and clinical services manager are on call after hours. All care staff interviewed report there is adequate staff available.

Resident information is entered into a register in an accurate and timely manner. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable.

Continuum of Service Delivery

The admitting registered nurse (RN) completes a range of assessments and develops detailed and comprehensive life style care plans to guide staff in service provision and reviews these within recommended timeframes. Observation of staff; review of patient notes; and resident and family interviews, confirm that all staff provide individualised care that reflects desired goals and outcomes.

A general practitioner (GP) is interviewed during the audit and confirms the facility RN's assessments are timely and appropriate, that he is notified in a timely manner, and he is very complimentary of the facility.

An activities programme is planned and implemented by the diversional therapist and the activities person, however it may not always meet the identified activities of all the residents, and individual resident's activity plans are not always developed, and are not reviewed in line with lifestyle plans and these areas need improvement.

Policies and procedures are in place for all stages of medication management. A robotic medication system is in place for the facility. The medication administration process is observed during the audit confirming safe practice occurs. Documented medication records are completed by the residents' GPs, however faxed records are not documented onto the original medication form and this requires improvement.

A dietary profile is completed for each resident on admission and updated as required. Special dietary requirements are met and personal likes and dislikes are catered for. Kitchen processes, including food preparation, transport, storage and removal of kitchen waste is appropriately

managed by the kitchen staff including two cooks. A nutritional review of the menu has occurred in the past year, and observation of the meals provided reflects the menu. Food, fridge and freezer temperatures are recorded daily, and observed to be within recommended levels.

Safe and Appropriate Environment

Bedrooms provide single accommodation with rest home rooms providing ensuites (toilets and wash hand basins), and hospital rooms providing full ensuites. Several of the bedrooms have shared ensuite facilities. There are also adequate toilet and shower facilities throughout the facility. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids, as well as a carer. There are separate lounges and dining areas throughout the facility. An external area is available for sitting and shade is provided. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for waste management, cleaning and laundry, and emergency management and these are known by staff. Staff receive training to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of sluice facilities, safe storage of chemicals and equipment, and that protective equipment and clothing is provided and is used by staff.

Review of documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment is safe, and facilities are fit for their purpose. All laundry is washed on site and cleaning and laundry systems include appropriate monitoring systems in place to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There are safe and hygienic storage areas for cleaning equipment, soiled linen and chemicals.

Restraint Minimisation and Safe Practice

Documentation of policies and procedures, staff training and the implementation of the processes demonstrate that residents are experiencing services that are the least restrictive. There are two residents using restraint and two residents using an enabler. The service has processes in place for determining restraint approval, consent from family and evidence of an assessment, monitoring and evaluation. Staff interviewed and files sampled evidence responsibilities are clearly identified and known. Residents' files show that there is family input into the restraint approval processes. Staff have training in managing challenging behaviour and restraint.

Infection Prevention and Control

A documented and implemented infection control (IC) programme which meets the infection control Standards includes policies and procedures to guide staff. Records sighted, observation, and interviews with staff provides evidence that all staff have a clear understanding of what is required for prevention of infections.

The enrolled nurse (EN) and the facility manager (FM) ensure the programme is implemented, collates and analyses IC data, and reports findings to the quality committee. During this routine process an increase in urinary tract infections prompted a quality improvement project to increase fluid intake, with an aim to reduce urinary tract infections. Evaluation has shown this to be beneficial to all residents, and this is identified as a continuous improvement.

The facility RNs and FM gain expert external advice as required, and the residents' GPs are also consulted regarding individual resident's infections.

All staff receive IC education as part of the induction process and at least annually. There is evidence that residents and family are educated in IC for specific practices, including increased fluids.

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	The Ultimate Care Group Limited		
Certificate name:	The Ultimate Care Group Limited - Kensington Court Lifecare		
Designated Auditing Agency:	The DAA Group Limited		
Types of audit:	Certification Audit		
Premises audited:	Kensington Court Lifecare		
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
Dates of audit:	Start date: 8 April 2013	End date: 9 April 2014	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			64

Audit Team

Lead Auditor	XXXXX	Hours on site	16	Hours off site	8
Other Auditors	XXXXX	Total hours on site	16	Total hours off site	8
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	4

Sample Totals

Total audit hours on site	32	Total audit hours off site	20	Total audit hours	52
Number of residents interviewed	6	Number of staff interviewed	17	Number of managers interviewed	3
Number of residents' records reviewed	8	Number of staff records reviewed	9	Total number of managers (headcount)	3
Number of medication records reviewed	16	Total number of staff (headcount)	70	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of The DAA Group Limited	Yes
b)	The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	The DAA Group Limited has provided all the information that is relevant to the audit	Yes
h)	The DAA Group Limited has finished editing the document.	Yes

Dated Wednesday, 30 April 2014

Executive Summary of Audit

General Overview

Kensington Court Lifecare provides residential care for up to 87 residents who require hospital and rest home level care. Occupancy on the day of the audit is at 64. The facility is operated by The Ultimate Care Group Limited. Staffing is stable with minimal turnover. Staff hours are increased if required to meet the needs of residents. Residents and family interviewed provide positive feedback on the care provided. There have been no changes to the facility, staffing structure, management or systems since the last audit.

One area has been rated as continuous improvement (beyond the standard normally expected) relating to a quality initiative implemented to reduce the rate of urinary tract infections in the facility. There are two areas identified that require improvement relating to documentation for activities, and documentation for medicine management.

Outcome 1.1: Consumer Rights

The facility ensures information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility's complaints process and the Nationwide Health and Disability Advocacy Service, is accessible and brought to the attention of residents' and their families on admission to the facility. All residents and family members interviewed verify that their rights are met at all times during service delivery, that staff are respectful of their needs, communication is appropriate, and they have a clear understanding of their rights, and the facility's processes if these are not met.

There is verification from residents and family that consent forms are provided prior to admission to ensure they have time for consultation and are fully informed. Time is provided if discussions and explanation is required. An older persons' advocate is available if required and is interviewed during the audit, confirming the facility encourages external support if required.

There is evidence of consideration of residents' personal choices, acknowledging and supporting cultural, spiritual and individual rights and beliefs, and encouraging independence.

The facility manager is responsible for management of complaints and a complaints register is maintained. The residents can use the complaints forms or raise issues at the residents' monthly meetings.

Outcome 1.2: Organisational Management

The Ultimate Care Group Limited is the governing body and is responsible for the service provided at Kensington Court Lifecare. A range of key planning documents were reviewed and include a vision statement and core values. Systems are in place for monitoring the service provided at Kensington Court Lifecare, including regular monthly reporting by the facility manager to The Ultimate Care Group Limited head office.

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Resident information is entered into a register in an accurate and timely manner. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable.

Outcome 1.3: Continuum of Service Delivery

The admitting registered nurse (RN) completes a range of assessments and develops detailed and comprehensive life style care plans to guide staff in service provision and reviews these within recommended timeframes. Observation of staff, review of patient notes, and resident and family interviews, confirm that all staff provide individualised care that reflects desired goals and outcomes.

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An activities programme is planned and implemented by the diversional therapist and the activities person, however it may not always meet the identified activities of all the residents, and individual resident's activity plans are not always developed, and are not reviewed in line with lifestyle plans and these areas need improvement.

Policies and procedures are in place for all stages of medication management. A robotic medication system is in place for the facility. The medication administration process is observed during the audit confirming safe practice occurs. Documented medication records are completed by the residents' GPs, however faxed records are not documented onto the original medication form and this requires improvement.

A dietary profile is completed for each resident on admission and updated as required. Special dietary requirements are met and personal likes and dislikes

are catered for. Kitchen processes, including food preparation, transport, storage and removal of kitchen waste is appropriately managed by the kitchen staff including two cooks. A nutritional review of the menu has occurred in the past year, and observation of the meals provided reflects the menu. Food, fridge and freezer temperatures are recorded daily, and observed to be within recommended levels.

Outcome 1.4: Safe and Appropriate Environment

Bedrooms provide single accommodation with rest home rooms providing ensuites (toilets and wash hand basins), and hospital rooms providing full ensuites. Several of the bedrooms have shared ensuite facilities. There are also adequate toilet and shower facilities throughout the facility. Residents' rooms are large enough to allow for the safe use of mobility aids, lifting aids, as well as a carer. There are separate lounges and dining areas throughout the facility. An external area is available for sitting and shade is provided. An appropriate call bell system is available and security systems are in place.

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Review of documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment is safe, and facilities are fit for their purpose. All laundry is washed on site and cleaning and laundry systems include appropriate monitoring systems in place to evaluate the effectiveness of these services. Staff have completed appropriate training in chemical safety. There are safe and hygienic storage areas for cleaning equipment, soiled linen and chemicals.

Outcome 2: Restraint Minimisation and Safe Practice

Documentation of policies and procedures, staff training and the implementation of the processes demonstrate that residents are experiencing services that are the least restrictive. There are two residents using restraint and two residents using an enabler. The service has processes in place for determining restraint approval, consent from family and evidence of an assessment, monitoring and evaluation. Staff interviewed and files sampled evidence responsibilities are clearly identified and known. Residents' files show that there is family input into the restraint approval processes. Staff have training in managing challenging behaviour and restraint.

Outcome 3: Infection Prevention and Control

A documented and implemented infection control (IC) programme which meets the infection control Standards, includes policies and procedures to guide staff. Records sighted, observation, and interviews with staff provides evidence that all staff have a clear understanding of what is required for prevention of infections.

The enrolled nurse (EN) and the facility manager (FM) ensure the programme is implemented, collates and analyses IC data, and reports findings to the quality committee. During this routine process an increase in urinary tract infections prompted a quality improvement project to increase fluid intake, with an aim to reduce urinary tract infections. Evaluation has shown this to be beneficial to all residents, and this is identified as a continuous improvement.

The facility RNs and FM gain expert external advice as required, and the residents' GPs are also consulted regarding individual resident's infections.

All staff receive IC education as part of the induction process and at least annually. There is evidence that residents and family are educated in IC for specific practices, including increased fluids.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	48	1	1	0	0	0
Criteria	1	97	1	1	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	0
Criteria	0	0	0	0	0	0	0	1

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.7: Planned Activities	Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low			
HDS(C)S.2008	Criterion 1.3.7.1	Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	Activity plans are not always developed, do not always reflect the resident's individual interests identified in the social profile, and are not reviewed at the time of the lifestyle plan as required in ARRC D 16c.	Activities plans are developed and reviewed to meet the interests, preference and ability of the resident as required in ARRC D16.5c.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>For example a resident who enjoys reading and visits the library once a week, and another resident who likes a particular genre of music and has an interest in crystals and minerals does not have this identified, or the assistance required by staff for the resident to participate in their preferred activities.</p>		
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Negligible			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Negligible	The prescriber does not document the medication onto the resident's medication chart, nor is an indelible record of the faxed order made on their chart, as required in the medication guidelines.	All medications are documented on the resident's medicine chart and signed by the prescriber, including faxed prescriptions, as required in the medicines care guidelines for aged care.	180

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(IPC)S.2008	Criterion 3.5.7	Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	Surveillance data is analysed with conclusions and recommendations to achieve infection reduction implemented, however the facility has responded to an increase in UTIs identified during routine analyses of quality data, and implemented a quality improvement project that includes all residents and staff. Initial evaluations show improved benefits for residents with a slight decrease in UTIs.

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

Attainment and Risk: FA
Evidence: Staff receive training in the Code of Health and Disability Services Consumers' Rights' (the Code) at least annually (records sighted). Care staff are observed interacting respectfully and communicating appropriately with residents. Staff allow residents to make choices demonstrating their knowledge of residents' rights. For example one of one resident chooses not to have tea with the other residents in the dining room, and this is supported by the staff. Residents (two hospital and four rest home) and family member (three hospital and two rest home) are able to verify that services are provided with dignity and respect at all times, privacy is maintained, and individual needs and rights are upheld. The ARRC requirements D1.1c; D3.1 are met.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Attainment and Risk: FA

Evidence:

Residents and family members interviewed confirm they are provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service in the facility's admission package prior to the resident's admission. Those interviewed verify explanations regarding their rights occur initially and on-going at any time that they may have a query. Those interviewed confirm that they are aware an advocate may be appointed if needed. On the day of the audit an elder person's advocate is interviewed and confirms the facility management and staff are very proactive in contacting the service if there is any indication that clarification regarding their rights is required.

A laminated poster of the Code is visible in three communal areas in the facility. Brochures of the Code and the advocacy service are available (sighted) at the entrance to the facility, and are included in the admission package, as verified by residents' and family interviewed.

The ARRC requirements D6.1; D6.2; D16.1b.iii are met.

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

Attainment and Risk: FA
Evidence: <p>There are clear and specific policy guidelines (sighted) relating to privacy and dignity for all staff when supporting residents. Observations during the audit verify residents are encouraged and supported to maintain independence, and are treated with dignity and respect that are reflective of the policy. For example residents are supported, and gentle encouragement is heard, to mobilise with aids. Bedroom doors are observed closed and curtains are drawn to protect resident's privacy when service delivery occurs.</p> <p>Documentation sighted (care plans) includes the cultural, spiritual and ethnic values and beliefs for each resident (five rest home and three hospital integrated files are reviewed). One of one Maori resident's file reviewed includes tribe, iwi, and the resident's choice not to identify as Maori.</p> <p>Policies and procedures relating to abuse and neglect prevention are sighted. Staff interviewed (three of three) are able to demonstrate knowledge in what abuse and neglect is, including the reporting processes. Residents and family members interviewed have not been subject to, or witnessed any abuse or neglect, and verify that they observe staff as always respectful to the residents.</p> <p>The ARRC D3.1b; D3.1d; D3.1f; D3.1i; D4.1a; are met.</p>

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Attainment and Risk: FA
Evidence:
The organisation has a Maori Health Plan that includes the three principals of the Treaty of Waitangi: Partnership, Participation and Protection. It describes that the holistic view of Maori health is to be incorporated into the delivery of services (whanau, hinangaro, tinana and wairua). <i>XXXXXX This information has been deleted as it is specific to the health care of a resident.</i>
The ARRC requirements A3.1; A3.2; D20.1i are met.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Attainment and Risk: FA
<p>Evidence:</p> <p>The Recognition of Individual Beliefs and Values policy (sighted) includes the identification of values and beliefs as part of the care planning process, as verified by resident and family interviewed and in residents' files reviewed. Staff receive regular training in supporting residents to achieve their values and beliefs and in assisting them to practice any cultural activities which they choose.</p> <p>The facility is able to access interpreters if required, however there are no residents for whom English is a second language, in the facility on the day of the audit.</p> <p>Residents and family members interviewed verify the facility regularly ensures their individual values and beliefs are met. They refer to their involvement in the care plan review.</p> <p>The ARRC requirements D3.1g; D4.1c are met.</p>

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Attainment and Risk: FA

Evidence:

Staff induction and orientation programme (sighted) includes expected behaviour in relation to discrimination, coercion, harassment, sexual, financial and other exploitation. Three of three staff interviewed confirmed that they do not accept gifts or any other inducement and can describe the facility's policy in relation to discrimination, harassment and other exploitation.

Residents and family interviewed confirm they have not been witness to any form of discrimination.

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Attainment and Risk: FA

Evidence:

Employment and induction are aligned to best practice processes. Each staff member has a written scope of practice included in their job description (sighted in staff files reviewed).

In-service education and on-going professional development is provided and supported by the organisation (records sighted). Policies and procedures are all current and reflect good practice guidelines.

Infection control surveillance is analysed and acted upon to ensure that practices implemented will benefit the residents in a reduction in infections (refer to CI rating criterion 3.5.7), ensuring evidence based practice occurs.

The facility's assessments and care plans are comprehensive and detailed and are reviewed every three months or sooner if required. Residents' files reviewed include multidisciplinary team (MDT) meetings and family communication forms completed in the timeframes specified.

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

There are procedure guidelines (sighted) for communicating with residents, relatives and visitors which sets out expected behaviours of staff, and this is observed during the audit to reflect the policy guidelines. For example, staff are heard addressing people as Mr or Mrs and their surname unless they have indicated to use a first name. The residents' preferred name is sighted on bedroom doors and white boards in the facility's kitchen and in each wing office.

Communication by staff is observed to be appropriate and residents are given time to answer and are not rushed. Residents and family members interviewed verify that staff ensure that they are understood and communication is respectful.

Open disclosure occurs according to the facility's policy (sighted). Indication of this is evident on two of two incident reports reviewed that show a family member has been notified. This is also verified in the family communication forms, documenting the discussion that took place.

The clinical nurse manager (CNM) is interviewed and verifies that interpreter services have not been used for any residents in recent months, but she is able to confirm how these needs would be met, if required.

The ARRC requirements are met.

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Attainment and Risk: FA
Evidence: <p>The Informed Consent policy (sighted) includes references to the Code in relation to competence and how to assess whether a resident is deemed medically unable to give informed consent themselves.</p> <p>Eight residents' files are reviewed and include consent for photographs to be displayed, residents name on the door and publicly displayed records to be retained, health information and care provision, advance directives, outings and flu vaccinations.</p> <p>Residents and family members confirm that staff gain consent for day to day activities on a daily basis. For example, one resident has a preferred dress and cardigan and staff ensure this is laundered in a speedy time so that she can wear the clothes again as soon as possible.</p> <p>Admission agreements are signed by the resident and/or their family member on admission to the facility, and information included is aligned to the ARRC agreement requirements. This is confirmed in eight of eight residents' agreements reviewed.</p> <p>The ARRC requirements D3.1d; D11.3; D12.2 are met.</p>

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained where required.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

Attainment and Risk: FA
Evidence: <p>Policies and procedures reviewed include the right for residents to have an advocate or support person of their choice at any time. The contact details for advocacy services and the Health and Disability Commissioner are included in the policy document. Residents and family interviewed verify that family and support persons are included in discussions relating to care provision initially and on-going during the review phase. This is confirmed in the multidisciplinary team (MDT) meeting records (sighted) that includes input from the resident’s family member.</p> <p>Care staff (interviewed) are aware of the residents’ rights to have a support person of their choice at any time and this has been facilitated by referring the resident to the elder person’s advocate (interviewed).</p> <p>The ARRC requirements D4.1d; D4.1e are met.</p>

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Attainment and Risk: FA

Evidence:

Residents and family interviewed confirm that family and visitors of their choice are able to visit residents at any time. External community links are encouraged and enabled to continue. One resident interviewed goes out to the nearby brewery once a week for contact with a friend. Progress notes and care plan content includes regular outings and appointments (records sighted).

The ARRC requirements D3.1h; D3.1e are met.

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when appropriate.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Attainment and Risk: FA
Evidence: <p>The service has appropriate systems in place to manage the complaints processes. A complaints register is maintained at the facility and there are 30 complaints recorded since the last audit. A complaints register is also maintained at The Ultimate Care Group (UCG) Head Office for complaints that are escalated up to them (not reviewed during this audit). Review of three complaints provides evidence that complaints are responded to within three days of receiving the complaints and closed out with satisfaction from the complainant documented. Reporting of complaints occurs via monthly meetings and via the managers' reports to the UCG Head Office. The facility manager (FM) reports there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents are advised on entry to the facility of the complaint processes and the Code. The admission information pack includes information on complaints and the Code and copies of these are given to all residents and their families as part of the admission process. Residents interviewed demonstrate an understanding and awareness of these processes. Residents meetings are held two monthly and review of these minutes provides evidence of the resident's ability to raise any issues they have, and this was confirmed during interviews of residents.</p> <p>A visual inspection of the facility evidences that the complaint process is readily accessible and/or displayed. Review of quality/health and safety/infection control, various staff meeting minutes and manager's monthly reports, evidences reporting of complaints.</p> <p>The district health board contract requirements are met.</p>

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Attainment and Risk: FA

Evidence:

The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided at Kensington Court Lifecare. A Kensington Court Lifecare Business Plan 2014', 'Quality Improvement Plan and 'Risk Management Plan 2014-2015' reviewed includes a vision statement, core values, quality objectives, quality indicators and quality projects, and scope of service. Also reviewed are documented values, mission statement and philosophy, which are displayed. The service philosophy is in an understandable form and is available to residents and their family/representative or other services involved in referring clients to the service.

UCG has established systems in place which defines the scope, direction and goals of the organisation and UCG facilities, as well as the monitoring and reporting processes against these systems. Interview of the Manager Audit and Compliance from UCG Head Office confirms reporting processes and monitoring of quality and risk management goals. The Kensington Court Lifecare facility manager (FM) and clinical services manager (CSM) provide weekly and monthly reports to the governing body and these are reviewed. Reports include reporting on quality and risk management issues, occupancy, HR issues, quality improvements, internal audit outcomes, and clinical indicators.

There is an 'Ultimate Care Group Clinical Advisory Group' (CAG) in place that has four clinical services managers (CSMs) that is responsible for reviewing clinical issues and policies and procedures following feedback from each of the 16 UCG sites. Each of the four CSMs is responsible for liaising with four or five UCG sites to ensure their participation in the process.

Meeting schedules and minutes reviewed show that monthly quality/health and safety/infection control, staff, and registered/enrolled nurses meetings are held, and resident meetings are two monthly. Meeting minutes are available for review by staff along with clinical indicator reports, graphs, and benchmarking data.

Kensington Court Lifecare has a facility manager/RN (FM) and a clinical services manager (CSM). The FM is a very experienced registered nurse who has been in this role at Kensington Court Lifecare for the last six years and was appointed to their current position in 2008. The clinical services manager has been in this role for the last two years and was a registered nurse(RN) working on the floor prior to this. There is good evidence of ongoing education for both managers reviewed. Review of the managers' personal file and interview of the FM and CSM indicates the managers undertake training in relevant areas.

Twenty four hour RN cover is provided and the CSM, and a senior RN in the absence of the CSM, is responsible for oversight of clinical care provided to residents. Support for the FM and CSM is provided by a Regional Operations Manager and the Audit and Compliance Manager for UCG.

Kensington Court Lifecare is certified to provide hospital and rest home level care and there are 87 beds provided. Ten bedrooms are able to be used for either rest home or hospital use. On day one of this audit there are 19 hospital residents and 45 rest home residents.

Ultimate Care Group Limited have contracts with the DHB to provide aged related residential care (rest home and hospital services), day and respite care. UCG also has a contract with Ministry of Health for residential - non aged services.

The district health board requirements are met.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Attainment and Risk: FA

Evidence:

There are appropriate systems in place to ensure the day-to-day operations of the service continues should the facility manager and/or the clinical services manager be absent. The clinical services manager relieves the facility manager if they are absent. A senior RN relieves the clinical services manager if the CSM is absent. Twenty four hour RN cover is provided. Both the FM and CSM share on call after hours and this information is recorded on the daily handover sheet.

An UCG Regional Operations Manager, and other personnel from UCG Head Office are also available for assistance and support as required. Services provided meet the specific needs of the resident groups within the facility. Job descriptions and interviews of the FM and CSM confirms their responsibility and authority for their roles.

The district health board requirements are met.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Attainment and Risk: FA

Evidence:

The Ultimate Care Group quality and risk management systems are fully imbedded at Kensington Court Lifecare. Kensington Court Lifecare has a well-established, documented, and maintained quality and risk management system that is maintained to an appropriate standard. There is evidence that quality improvement data is collected, collated, and analysed to identify trends and corrective actions improve service delivery, including clinical indicators - falls (with or without injury), skin tears, infections, urinary tract infections, behaviours, medicine errors, unintentional weight loss, and sentinel events. Quality and risk issues, and discussion of any trends identified in the monthly quality and staff meetings are also sighted. As part of this process the service provider has identified an area that requires improvement and undertaken a quality improvement project that includes monitoring and evaluation to ensure the improvements required have been made. There is evidence of improvements to service delivery as a result of this quality improvement project. As a result, one criterion (3.5.7) is rated continuous improvement.

UCG launched 'Releasing Time to Care' (RTTC) modules at some trial sites in January 2012 and rolled it out to all UCG sites in August 2012. Kensington Court Lifecare have integrated the RTTC modules in to their service.

There is an internal audit programme in place and completed internal audits for 2013 and 2014 are reviewed. Review of quality improvement data provides evidence the data is being reported to Ultimate Care Group Head Office via their intranet as well as to various staff meetings. Combined quality improvement/health and safety/infection control, staff meetings, and RN/EN meetings are held monthly. There is documented evidence of reporting on numbers of clinical indicators and quality and risk issues in these meetings. Resident meetings are held two monthly.

A food service and family and residents satisfaction survey was completed in 2013. Collated results are reviewed and indicate the majority of responders are either satisfied or very satisfied with the various aspects of service provided.

The Ultimate Care Group (UCG) 'Quality and Risk Management Plan 2014-2015' is used to guide the quality programme and includes quality goals and objectives.

UCG implemented an electronic database (Inscribe database) in December 2012 which is used to input clinical indicators on a daily basis. This information is available for review by staff at UCG head office. Information on this database, including benchmarking graphs (reviewed).

Staff interviewed report they are kept well informed of quality and risk management issues including clinical indicators. Copies of meeting minutes are available for staff to review in the staff office. Graphs of clinical indicators are attached to the meeting minutes and are displayed in staff areas.

The managers are responsible for providing a 'Weekly and Monthly Report' to UCG Head Office and these provide evidence of reporting of clinical indicators and quality improvements - including education and internal audits. Other areas reported on include occupancy, staffing and HR, resident 'ins and outs', property/environmental issues, financial, general comments, compliance/indicator summary.

Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed that are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies/procedures are available with systems in place for reviewing and updating the policies and procedures regularly, including a policy for document update reviews and document control policy. The CAG from UCG is responsible for

reviewing policies and procedures. Staff signing sheet demonstrates staff have been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies/revised policies via handover and meetings.

There is a Health & Safety Manual available that includes relevant policies and procedures. There is a hazard reporting system available and a hazard register that identifies various potential and actual risks including health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk. Chemical safety data sheets are available identifying potential risks for each area of service. Planned maintenance and calibration programmes are in place and reviewed and all biomedical equipment has appropriate performance verified stickers in place.

The district health board requirements are met.

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

The organisation has a quality and risk management system which is understood and implemented by service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Attainment and Risk: FA
Evidence: The adverse event reporting system provides evidence of a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are then recorded on the UCG Inscribe electronic database, and graphed and benchmarked with four other facilities of similar size and type. Completed original incident/accident forms are held in the residents't files, and a copy held on file by the FM. 2013 and 2014 data reviewed includes summaries and

registers of various clinical indicators including falls, medication errors, unintentional weight loss, skin tears, and behaviour. Documentation reviewed and interviews of staff indicates appropriate management of adverse events.

An 'Incident Management Form' is used to document all incidents that are referred to UCG head office.

There is an open disclosure policy. Eight residents' files reviewed provide evidence of communication with families following adverse events involving the resident, or any change in the resident's condition. Three family members interviewed provide evidence that communication is very good, and staff advise them following incidents/accidents.

Staff confirm during interview that they are made aware of their essential notification responsibilities through: job descriptions; policies and procedures; and professional codes of conduct; which was confirmed via review of staff files and other documentation. Policy and procedures comply with essential notification reporting (eg, health and safety, human resources, infection control).

The district health board requirements are met.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: FA

Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: FA
<p>Evidence:</p> <p>Written policies and procedures in relation to human resources management are available and reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority, which were reviewed on staff files (nine of nine) along with employment agreements, criminal vetting, completed orientations and competency assessments.</p> <p>The FM is responsible for management of the inservice education programme and there is evidence available indicating inservice education is provided for staff at least monthly. Three study days are also held per year and staff are expected to attend one of these. A number of subjects are included – Code of Rights, informed consent, open disclosure, elder abuse and neglect, challenging behaviours, and restraint. All RNs, diversional therapist and activities coordinators have current first aid certificates.</p> <p>Individual records of education are maintained for each staff member and copies are reviewed on staff files. Also viewed are competency assessment and education spreadsheets, as well as education records for each session, and inservice education programmes.</p> <p>An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff advise they are 'buddied' with an experienced staff member for at least three days at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed by the FM at the end of this period. Orientation for staff covers the essential components of the service provided (ie, the quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation's vision, values and philosophy, Code of Rights, incident/accidents, complaints, infection control, challenging behaviours and health and safety). There are currently eight RNs, three ENs, and 35 caregivers employed.</p> <p>A caregiver who is the Careerforce assessor, is responsible for managing the Careerforce education modules, including the dementia specific module. All caregivers are required to complete the Careerforce modules and it is UCG policy that all RNs complete the dementia education modules. All caregivers have either started or completed these modules.</p>

An appraisal schedule is in place and current staff appraisals are sighted on all staff files reviewed. Annual practising certificates are current for all staff who require them to practice – RNs, ENs, pharmacist, podiatrist, physiotherapist, dietitian, and GPs.

Care staff interviewed (five caregivers, two RNs and one EN) confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

The district health board requirements are met.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA

Evidence:

There is a clearly documented staffing rationale policy for determining service provider levels and skill mixes in order to provide safe service delivery at Kensington Court Lifecare. The staffing rationale is based on 'SNZ:HB 8163:2005 Indicators for Safe aged-care and dementia-care for Consumers' - 'Table 4 Recommended hours per consumer'. 'The Ultimate Care Group Rostering Tool' is used by the facility manager to report to UCG head office on a weekly basis. Registered nurse cover is provided 24 hours a day. The minimum amount of staff is provided during the night shift and consists of one registered nurse and three caregivers. The clinical services manager and facility manager share on call after hours.

Caregivers, RNs, and the EN interviewed report that there is enough staff on duty and they are able to get through the work allocated to them. Residents interviewed report there is generally enough staff on duty to provide them with adequate care.

The district health board requirements are met.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Attainment and Risk: FA

Evidence:

Eight residents' files are reviewed. Information is entered onto an admission form in a timely manner and included as the front sheet in the integrated notes. A label is developed for all patients and fixed to each record as sighted in all pages in the files reviewed. All records are observed to be stored in the office area. Records reviewed are legible and the name and the designation of the provider is identifiable.

Archived files are securely stored and easily retrieved.

The relevant ARRC requirements are met.

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Attainment and Risk: FA

Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.3: Continuum of Service Delivery

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

Attainment and Risk: FA

Evidence:

The entry to service package includes admission information and a brochure that details all requirements for both parties on admission to the facility. Admission agreements are completed for all residents (three hospital and five rest home records sighted). A needs assessment and service co-ordination (NASC) assessment occurs prior to all admissions (records sighted) to ensure admission is appropriate.

Residents and family interviewed verify the facility ensured the admission was timely and managed with dignity and respect, taking into account the family and resident's identified needs.

There is a comprehensive assessment process on admission and on-going to ensure that all the residents identified needs are met (documentation sighted). The admission agreement includes a statement as to when the facility requires a 'difficult resident' to leave the facility, however the clinical nurse manager (CNM) during interview confirms this has not been required.

The relevant ARRC requirements are met.

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Attainment and Risk: FA
Evidence: The facility manager and the CNM (both interviewed) manage admissions prior to acceptance to ensure the admission is appropriate. There have been no instances when the facility’s management have declined entry, as the admission screening process is managed by NASC. When a resident becomes unsuitable for the facility, this is then referred to NASC, however this has not occurred since the previous audit.

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Attainment and Risk: FA

Evidence:

Three hospital and five rest home residents' files are reviewed.

All files reviewed have an InterRAI assessment completed prior to admission to the facility. Care plans are developed within required timeframes based on NASC, general practitioner (GP) and registered nurse (RN) assessments. The long term lifestyle plan includes nursing diagnosis, goals and timeframes, identified needs, and interventions in all service areas, including personal care needs, skin care, elimination, respiration, cardiovascular, communication and sensory, mobility, pain and comfort, safety, social needs, including sexuality, cultural and spiritual, nutrition, continence and behaviour needs.

A short term care plan has been developed if required for skin tears, wounds, cellulitis, conjunctivitis, and mobility issues (sighted).

Discussion with care staff and observation during the audit provide evidence that consultation with the RN relating to service provision occurs regularly. Care staff (interviewed) are observed consulting the care plan to verify the residents' care needs. Interview with one carer verifies she provides services reflective of the care plan content.

A late morning 'catch-up' meeting is observed during the audit and confirms staff refer to handover notes as a reference and the content is consistent with the progress notes written for each shift (records sighted).

The facility has at least seven general practitioners (GP) who visit the residents. One GP is interviewed and confirms the facility provides an excellent level of care and assessments and he is always notified in a timely manner of any issue. He is involved with the multidisciplinary team (MDT) meeting, and is complimentary of the CNM and the facility's RNs.

Family contact occurs regularly either verbally on site or by phone, as recorded in the family contact form, or as part of the MDT meeting process (records sighted).

Tracer methodology T1

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Tracer methodology T2

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

The relevant ARRC requirements D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c; D16.5c.ii; D16.5e are met

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Attainment and Risk: FA
<p>Evidence:</p> <p>Prior to admission the NASC agency completes an InterRAI assessment to ensure that resident placement is appropriate. The facility RN completes appropriate resident assessments (records sighted) on admission to the facility. In all files reviewed assessments completed include a pressure area risk assessment; falls risk assessment, continence assessment, nutritional assessment, pain and oral assessment. If required a wound assessment is completed. Those reviewed are detailed and comprehensive and are used as the basis of care planning (records sighted). Goals are developed based on the nursing diagnosis and those reviewed are individualised and specific to the issue identified during the assessment process.</p> <p>Resident files reviewed are completed in a timely manner by the RN. If an issue arises within the three months, an appropriate assessment tool is completed prior to the development of a short term care plan. For example, one resident has an on-going issue causing decreased mobility. A falls risk assessment is completed (documents sighted) and a short term care plan is developed, as the resulting mobility issues have increased the falls risk status. At the three month review, the short term care plan is closed and the mobility issue is transferred to the lifestyle plan, including the increased falls risk.</p> <p>The ARRC requirements D16.2 are met.</p>

Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

Attainment and Risk: FA

Evidence:

Three hospital residents and five rest home residents' files are reviewed. The initial care plan is developed following an InterRAI assessment and within timeframes to safely meet the resident's needs. The long term lifestyle care plan is developed within three weeks of admission (records sighted). When progress is less than expected, the RN (interviewed) will develop a short term care plan, using appropriate assessment tools (documentation sighted).

There is evidence of integration from allied health in the care plans sighted. For example, one resident requires input relating to dietary supplements, and a referral to the dietitian to manage her decreased appetite and loss of weight. The GP and dietitian's recommendations are included in the integrated notes and lifestyle plan. As time has progressed, the resident's weight has stabilised and her appetite improved, so dietary supplements have been discontinued (records sighted).

Three of three care staff interviewed confirm the care plans are easy to follow and are able to describe interventions reflective of the care plan. Care staff, the RN and CNM meet at a 'catch up' meeting late each morning (observed) to discuss care provision that is reflective of the care plan content.

The relevant ARRC requirements are met.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Attainment and Risk: FA

Evidence:

The facility's RN documents appropriate interventions on the resident's short term or lifestyle care plan, based on prior assessments. Lifestyle plans reviewed are consistent with meeting the resident's identified needs and outcomes, are evaluated regularly and the lifestyle plan is either updated or a short term care plan is developed. Progress notes are written by care staff and those sighted confirm residents' needs are met and service delivery is provided in a timely manner. Staff are observed providing care to residents based on the lifestyle plan intervention.

GP assessments sighted are detailed on the medical clinical form in the integrated resident's file and the subsequent intervention are included on the resident's short term care plan (sighted).

Residents and family interviewed confirm service delivery is consistent with meeting the resident's desired outcomes and they are involved in the review process, as evidenced in the family communication form and residents' MDT team meetings (records sighted).

The ARRC requirements D16.1a; D16.1b.i; D16.5a; D18.3; D18.4 are met.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Attainment and Risk: PA Low
Evidence: Five hospital residents' files are reviewed (the sample is extended to provided conformity) and five rest home files are reviewed. A social profile is developed on admission to the facility in all those that are reviewed. An activity plan is developed following the completion of the resident's lifestyle plan. However, in the hospital wing three of five plans have not been developed, and of those reviewed activity plans do not always reflect the resident's individual interests identified in the social profile, and are not reviewed at the time of the lifestyle plan. For example, a resident who enjoys reading and visits the library once a week, and another resident who likes a particular genre of music and has an interest in crystals and minerals, does not have this identified in the activity plan, and it does not include the assistance required by staff in the activities they do attend. One to one activity preferences are not always included in the activity plan, and do not always occur. These are areas that require improvement.

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: PA Low
Evidence: Five hospital residents' files and five rest home activity files are reviewed. A social profile is developed on admission to the facility in all those that are reviewed. An activity plan is developed following the completion of the resident's lifestyle plan, however in the hospital wing three of five files reviewed do not have an activity plan developed, and this requires improvement.

Activity plans reviewed do not always reflect the resident's individual interests identified in the social profile, and are not reviewed at the time of the lifestyle plan. For example, a resident who enjoys reading and visits the library once a week, and another resident who likes a particular genre of music and has an interest in crystals and minerals, does not have this identified in the activity plan, and it does not include the assistance required by staff in the activities they do attend.

Finding:

Activity plans are not always developed, do not always reflect the resident's individual interests identified in the social profile, and are not reviewed at the time of the lifestyle plan as required in ARRC D 16c. For example a resident who enjoys reading and visits the library once a week, and another resident who likes a particular genre of music and has an interest in crystals and minerals does not have this identified, or the assistance required by staff for the resident to participate in their preferred activities.

Corrective Action:

Activities plans are developed and reviewed to meet the interests, preference and ability of the resident as required in ARRC D16.5c.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA

Evidence:

The facility's CNM is interviewed and the RN in each wing, regarding care plan evaluations. Eight residents' files are reviewed (three hospital and five rest home) and all are evaluated three monthly in line with the facility's policy (records sighted). Appropriate assessments are completed prior to the review of the care plan and the assessment content reflects the updated care plan. The facility also evaluates residents' care if progress is less than expected, using the relevant assessment tools. A short term plan is then developed indicative of the resident's changed needs. Records sighted include short term care plans reflective of their changed needs, and evaluations are included following resolution of these.

Residents and family members interviewed verify they are included in care plan evaluations as part of the MDT process (records sighted) and there is evidence of this also documented in the residents' progress notes (sighted). Care staff interviewed are able to demonstrate knowledge in following short term care plans and evaluations when needs change.

The ARRC requirements D16.3c; D16.3d; D16.4a are met.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Attainment and Risk: FA

Evidence:

Eight residents' integrated files are reviewed and the CNM and the RN is interviewed. Four of four files, reviewed have evidence of referral to other health and disability services. For example, two residents have been referred to a physiotherapist, one resident referral is to a psych geriatrician, and another has a referral to a dietitian. Referrals are included in the integrated notes (sighted). The allied health professional that visits the facility documents recommendations in the integrated notes (records sighted for physiotherapists consultation).

The CNM (interviewed) confirms that, if required, the facility will accompany residents on appointments if the family member is unavailable. During the audit a resident accident occurred. Staff are observed managing this in a calm, timely and appropriate manner, ensuring the resident is safely and quickly transferred via ambulance to the hospital.

Family and residents (interviewed) provided examples of input from other health and disability services, including the Nelson hospital outpatient services and the dietitian.

The ARRC requirements D16.4c; D16.4d; D20.4 are met.

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

Attainment and Risk: FA

Evidence:

One discharged resident's file is reviewed, and one transfer to and from hospital. The CNM is interviewed and verifies all discharges include the involvement of the resident, family and GP and this is confirmed in documentation sighted. A discharge or transfer form is completed (sighted) and details any persons involved, any risks and measures to minimise the risk. The file reviewed is completed with evidence of family and GP involvement prior to the discharge and ensuring the resident's medications are available following discharge.

The ARRC requirements D21 are met.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Attainment and Risk: PA Negligible

Evidence:

Policies and procedures for medication management reviewed detail each health professional's responsibility in relation to medicine prescribing, administration, reconciliation, dispensing, storage and disposal.

The facility has a robotic medication system in place for all residents requiring medication assistance. The robotic packs are reconciled into the facility by the night RN (records sighted) once per month. Discontinued medications are returned to the pharmacy at least daily if required, including controlled medications as sighted in records signed by the RN and the pharmacist.

The resident's prescription medication record is completed by the resident's GP and administered by the facility care staff. The typed record is legible and each record signed individually by the GP including when discontinued. The prescriber faxes medication prescriptions to the facility (sighted for two of two medications) and the facility staff administer medications based on the faxed information. The prescriber does not update the resident's medication chart, nor is an indelible record of the prescription made, as required in the medication guidelines, and this requires improvement.

A GP contacts the auditor during the audit regarding faxed prescriptions and states that there is a working group consulting the Ministry of Health and the GP is expecting there to be a waiver regarding faxed prescriptions, however at the time of the audit this has not occurred, but mitigates the risk to low.

An enrolled nurse (EN) and a RN are observed administering medications on the days of the audit. Both have medication competencies (sighted). The medication trolley holds all current medication, robotic packs and medication records and is observed to be locked when not in use, and stored in the key pad secured medication room.

Controlled drugs are reviewed and storage in line with guidelines. There is a separate medication fridge and temperatures are recorded (observed) and within recommended guidelines.

Sixteen medication files are reviewed. PRN (pro re nata) medication is recorded to a level of detail to indicate the intended use, for example for nausea, chest pain, coughing and pain.

There are no residents who self-medicate, although there are policies, procedures and resources in place should this occur.

The ARRC requirements D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d are met.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: PA Negligible
Evidence: <p>Policies and procedures for medication management reviewed detail each health professional's responsibility in relation to medicine prescribing, administration, reconciliation, dispensing, storage and disposal. The facility has a robotic medication system in place for all residents requiring medication assistance.</p> <p>The resident's prescription medication record is completed by the resident's GP and administered by the facility care staff. The typed record is legible and each record signed individually by the GP including when discontinued. The prescriber faxes medication prescriptions to the facility (sighted for two of two medications) and the facility staff administer medications based on the faxed information. The prescriber does not update resident's medication chart, nor is an indelible record of the prescription made, as required in the medication guidelines, and this requires improvement.</p> <p>A GP contacts the auditor during the audit regarding faxed prescriptions, and states that there is a working group consulting the Ministry of Health and that it is expected that there is to be a waiver regarding faxed prescriptions, however at the time of the audit this has not occurred, but mitigates the risk.</p>
Finding: <p>The prescriber does not document the medication onto the resident's medication chart, nor is an indelible record of the faxed order made on their chart, as required in the medication guidelines.</p>
Corrective Action: <p>All medications are documented on the resident's medicine chart and signed by the prescriber, including faxed prescriptions, as required in the medicines care guidelines for aged care.</p>
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: FA

Evidence:

Policies and procedures are in place for all aspects of food service, delivery, preparation, service, storage and disposal and cleaning (sighted).

A nutritional audit of the menus has been undertaken by a dietitian in May 2013 (sighted). The menu content on the day of the audit reflects the version in use by the facility, and the dietitian's recommendations are observed to have been implemented. Two cooks (both interviewed) share food preparation and kitchen duties, and are supported by care staff designated for kitchen duties.

Dietary profiles are written on admission (eight of eight dietary profiles are reviewed), and these include likes and dislikes, preferences for beverages, and any other special dietary instructions. The RN or CNM will inform the kitchen if there are any changes in dietary requirements. Residents' preferences are listed and catered for (verified in resident and family interviews).

Residents and family members interviewed also confirm there is variety in the food provided, it is sufficient and meets their needs. There are some weight issues with residents, however these are being managed appropriately with supplements, GP and dietitian intervention. Observation of meal service confirms that residents enjoy the meals provided. A review of residents' meetings minutes and survey results verifies that discussion regarding food are complimentary.

Food and fridge temperatures are recorded and those reviewed are within recommended guidelines.

The ARRC requirements D1.1a; D15.2b; D19.2c are met.

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Attainment and Risk: FA

Evidence:

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on. Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and are free from damage. Material Safety Data Sheets are available throughout the facility and are accessible for staff. The Hazard Register is sighted and is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances and education was last provided in July 2013. There are monthly visits by an Ecolab representative who reviews kitchen, cleaning and laundry processes. Copies of these reports are reviewed during this audit.

A visual inspection of the facility provides evidence that protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substance being handled are provided and are being used by staff. For example, goggles/visors, gloves, aprons, footwear, and masks are viewed in sluice rooms.

Visual inspection of the facility provides evidence that hazardous substances are correctly labelled, and the container is appropriate for the contents, including container type, strength and type of lid/opening. There are two sluice rooms available, one in the hospital area and one in the main laundry for the disposal of waste and hazardous substances.

The district health board requirement is met.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Attainment and Risk: FA
Evidence:
<p>Review of documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. A maintenance person is interviewed during and confirms there is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Documentation reviewed and visual inspection confirms this. Planned and reactive maintenance systems are in place and reviewed along with current calibration / performance verified stickers in place on medical equipment. The service provider's documentation and visual inspection evidences a current Building Warrant of Fitness that expires 1 March 2015.</p> <p>A visual inspection of the facility provides evidence of safe storage of medical equipment and the building, plant and equipment is maintained to a high standard. Corridors allow residents to pass each other safely; safety rails are secure and are appropriately located; equipment does not clutter passageways; floor surfaces/coverings are appropriate to the resident group and setting; floor surfaces and coatings are maintained in good order. The external areas are safely maintained and are appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the area. Residents are protected from risks associated with being outside (eg, safe flooring/pavement surfaces; provision of adequate and appropriate seating; provision of shade; provision of appropriate fencing; and ensuring a safe area is available for recreation or evacuation purposes).</p> <p>Staff receive education in the safe use of medical equipment by suitably qualified personnel, and there is a system in place to review staff competency for specific equipment (eg, hoists competency). This was confirmed via interview of staff and review of staff education records. Care staff interviewed confirm that they have access to appropriate equipment, equipment is checked before use, and they are competent to use the equipment.</p>

Residents and family interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents interviewed confirm they are able to move freely around the facility and that the accommodation meets their needs.

The district health board requirements are met.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence:
<p>Bedrooms provide single accommodation and all rest home bedrooms have ensuites (toilet and wash hand basin). Hospital bedrooms have their own full ensuites and four have shared full ensuites. There is an adequate number of communal toilet and shower facilities available throughout the facility. Visual inspection provides evidence that toilet, shower and bathing facilities are of an appropriate design and number to meet the needs of the residents. All toilets have appropriate access for residents based on their needs and abilities. There are clearly identified toilet/shower and wash basin facilities that meet specifications for people with disabilities that are large enough for easy manipulation of mobility aids and where practicable, provide working space for up to two service providers. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant.</p> <p>The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored at monthly intervals and are delivered in line with the recommended temperature range contained in BIA Approved Document G12 Water Supplies as determined by the Building Regulations 1992 (Acceptable Solutions).</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence</p>

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: FA
Evidence: Visual inspection provides evidence that adequate personal space is provided in bedrooms to allow residents and staff to move around within the room safely. This finding was confirmed during interviews of staff, residents and family. Bedrooms used for hospital level care residents have 'double leaf' doors and are large enough to allow for easy access for mobility aids.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

Visual inspection provides evidence that adequate access is provided to lounges and dining rooms. Residents are observed moving freely within these areas. Residents interviewed confirm there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Attainment and Risk: FA

Evidence:

Cleaning policy and procedures and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals/poisons.

The laundry is a good size with adequate dirty/clean flow. All linen is washed on site and the laundry person interviewed describes management of laundry, including transportation, sorting, storage, laundering, and return to residents.

The implementation of cleaning and laundry processes is evident. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning are reviewed, along with monthly Ecolab reports. A cleaner is interviewed and describes cleaning processes, and a cleaning check list is sighted, including cleaning of a room following resident discharge. The cleaner signs and dates this when completed.

Visual inspection of the facility evidences: safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available; appropriate facilities exist for the disposal of soiled water/waste (ie, sluice rooms; convenient hand washing facilities are available; and hygiene standards are maintained in storage areas).

Residents and family interviewed state they are satisfied with the cleaning and laundry service and this finding is confirmed during review of satisfaction surveys completed in 2013.

The district health board requirements are met.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Attainment and Risk: FA

Evidence:

Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements appropriate to the resident group and setting along with policy/procedures for visitor identification. There are also policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors.

A New Zealand Fire Service letter (dated 15 February 2012) advising evacuation scheme approval is sighted. The last trial evacuation was held on 7 April 2014.

All registered nurses, the diversional therapist and activities co-ordinator are required to complete first aid training, including CPR training. There is at least one designated staff member on each shift with appropriate first aid training. External doors are locked at dusk and an security firm carries out a round of the facility during the night.

Staff interviews and review of files provides evidence of current training in relevant areas. Staff confirm recent education on fire, emergency and security situations. Emergency and security situation education is provided to staff during their orientation phase and at appropriate intervals. Staff records sampled evidences current training regarding fire, emergency and security education.

There are emergency response flowcharts in both nurses' stations, equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. Oxygen is maintained in a state of readiness for use in emergency situations.

A visual inspection of the facility evidences emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones.

There is a call bell system in place that is used by the resident or staff member to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible and are available in resident areas (eg, bedrooms, ablution areas, ensuite toilet/showers). Residents interviewed confirm they have a call bell system in place which is accessible and staff generally respond in a timely manner.

The district health board requirements are met.

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA
Evidence:
<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Under floor heating heats the facility. There is a designated external smoking area.</p> <p>Residents and family interviewed confirm the facilities are maintained at an appropriate temperature.</p> <p>The district health board requirement is met.</p>

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

There are currently two residents using restraint and two residents using an enabler. Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrate residents are experiencing services that are the least restrictive. The restraint coordinator states they are actively reducing restraint use, and managing residents by using low beds, and sensor mats.

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that include responsibilities for key staff at an organisational level and the service level and is reviewed during this audit. The restraint co-ordinator is a RN and during interview they are able to describe the role and responsibilities of the position. Restraint co-ordinator's job description was sighted in the RN's personal file. The restraint approval group meets six monthly - minutes sighted for 28 February 2014.

The district health board requirement is met.

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

Assessments are completed for residents using restraint as sighted in the residents' files reviewed. Care plans reviewed indicate that the assessments are undertaken by suitably qualified and skilled staff in partnership with the resident and their family. This finding is confirmed during interview of a resident. The 'Resident Restraint/Enabler Assessment Form' documents that the RN, family and GP are involved.

ARC requirement is met.

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

The restraint assessment form identifies that the key relevant aspects of this standard is included in any assessment of restraint. There is an assessment process and it includes consultation with the resident and family and is reviewed on residents' files. A restraint register is maintained that records the two restraint and two enabler users and is reviewed.

Monitoring forms reviewed provide evidence that residents using restraint are monitored on a regular basis; information is recorded on the monitoring form.

The district health board requirement is met.

Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

Restraint evaluation processes are documented in the restraint minimisation and safe practice policy which is reviewed. The residents' files evidence that each episode of restraint is being evaluated at least three monthly, and more often, based on the risk to the resident and any changes.

Meeting minutes reviewed and interview of the CSM indicates that restraint practices are discussed at restraint approval meetings, and individual residents are also reviewed. Restraint is also reviewed as part of the care plan evaluation, as sighted in one resident's file.

Audits for management of challenging behaviours were last completed 11 April 2013 and restraint 28 May 2013.

The district health board requirement is met.

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

Attainment and Risk: FA
Evidence: <p>The restraint coordinator reports the use of any restraint is reviewed at the time of the individual resident care plan evaluation as well as approval meetings sighted. . Facility wide review is also undertaken at the approval meetings. All staff interviewed confirmed knowledge of the use of restraint and enablers. Audits for management of challenging behaviours were last completed 11 April 2013 and restraint 28 May 2013.</p> <p>The District Health Board contract requirement is met.</p>

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

<p>Infection control policies and procedures are reviewed and include the role and responsibility for infection control, the link to the quality meetings and organisational management. The infection control (IC) programme is reviewed annually (sighted) with clear lines of accountability and this is approved by the facility manager. All requirements of the IC standard are included. The EN (interviewed) and the facility manager (FM) interviewed, share the IC co-ordination role. The EN collects all data monthly and documentation is provided to the FM for review and analysis, providing a summarised report at the quality meeting (meeting records sighted). There is a report provided to staff at their monthly meeting (records sighted). Care staff interviewed are able to demonstrate their knowledge on observing, reporting and documenting infections.</p>

<p>The facility's front entrance notice requests persons with 'flu' not to visit and hand gel is available at the front door and throughout the facility for any visitor or resident to use. If there are any internal infections, the facility has processes in place to prevent visitors and to isolate the infection. There has been no internal infections in recent years.</p>

<p>The ARRC requirements D5.4e are met</p>
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Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The FM and the EN share the IC co-ordination role, have experience and have attended relevant on-going training in IC (records sighted). The EN documents resident specific IC information, including treatments and conclusions, and provides monthly reports to the FM who analyses the data and tables a summary to the quality meeting monthly (records sighted). A report is included in the agenda for monthly staff meetings (minutes sighted).

Expert advice is gained from the IC specialist and microbiologist at the Nelson Marlborough DHB and the resident's GP as required for any resident with an infection (confirmed in GP interview).

Residents and family interviewed verify they are advised of infections and treatments. Observed throughout the facility is hand gel and soap dispensers and education on hand hygiene on walls above hand basins. The facility has an up to date outbreak kit (sighted). There have been no reported outbreaks of infections.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Attainment and Risk: FA

Evidence:

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The FM and the EN are experienced in IC and documents sighted verify that they provide relevant initial and on-going education for staff. IC education is provided initially on induction (eight staff files reviewed), and then annually as part of the internal education programme (records sighted). Care staff interviewed confirm their participation in IC training and demonstrate IC practices (observed). A notice at the front entrance and above communal hand basins provides visual aid in the correct hand hygiene methods (sighted). One of one family member interviewed confirms that staff have advised him of IC practices to undertake prior to attending, and assisting with his wife.

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA

Evidence:

A form for the purpose of collecting monthly data on all infections is maintained by the EN in each wing office (sighted). The FM collects the monthly report sheets and the information is transferred to an organisation wide electronic data analyses sheet (sighted), listing specific infections of urinary tract, skin and wound, eye, respiratory tract, skin and wound and gastro-enteritis infections.

Documentation sighted includes the collection, collation and analysis of information on infections and the measurement of incidence and recommendations for minimising infections.

Evidence in the last two quality meeting minutes and staff meeting minutes verify that IC surveillance, analyses, conclusions and specific recommendations to minimise reduction in infection have been documented and reported to the organisation.

On analysing the data in 2012/2013 and 2013/2014 periods, there was a noted increase in urinary tract infections (UTI's) during the summer months (December to March) in both hospital and rest home wings. The surprise was the increase in the rest home, where many residents were able to independently access fluids and toilet. The FM and the quality team implemented a quality Improvement project to reduce UTI's in the summer months initially by 50% (analyses data and meeting records sighted).

Several factors were identified for improvement:

- 1: The amount and frequency of fluid intake by residents - was directly related to going to the toilet as a struggle for some (transfer and sit), and the time between fluid intake related to this, as residents did not always want to take fluids if toileting was difficult.
- 2: Knowledge – residents understanding that regular fluid intake can minimise the risk of getting a UTI.
- 3: Medical diagnosis – those with dementia often forgot to drink.

The FM and the quality team implemented an extra fluid round (observed) with education to residents at the time regarding the benefit of extra fluids, and education of staff that each time they enter a room or attend to a resident, fluids will be offered.

Initial evaluations (records sighted) have been encouraging with benefits to residents, showing a slight reduction in UTI's in the initial implementation of the quality improvement project. Residents interviewed confirm the reason for and benefits of the extra fluid round. This is an area of continuous improvement.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: CI
Evidence: <p>The FM collects the monthly report sheets and the information is transferred to an organisation wide electronic data analyses sheet (sighted), listing specific infections of urinary tract, skin and wound, eye, respiratory tract, skin and wound and gastro-enteritis infections.</p> <p>On analysing the data in 2012/2013 and 2013/2014 periods, there was a noted increase in urinary tract infections (UTI's) during the summer months (December to March) in both hospital and rest home wings. The surprise was the increase in the rest home, where many residents were able to independently access fluids and toilet.</p> <p>The FM and the quality team implemented a quality Improvement project to reduce UTI's in the summer months initially by 50% (analyses data and meeting records sighted).</p> <p>Several factors were identified for improvement;</p> <ol style="list-style-type: none">1: The amount and frequency of fluid intake by residents - was directly related to going to the toilet as a struggle for some (transfer and sit), and the time between fluid intake related to this, as residents did not always want to take fluids if toileting was difficult.2: Knowledge – residents understanding that regular fluid intake can minimise the risk of getting a UTI.3: Medical diagnosis – those with dementia often forgot to drink. <p>The FM and the quality team implemented an extra fluid round (observed) with education to residents at the time regarding the benefit of extra fluids, and education of staff that each time they enter a room or attend to a resident, fluids will be offered (observed).</p> <p>Initial evaluations (records sighted) have been encouraging with benefits to residents, showing a slight reduction in UTI's in the initial implementation of the quality improvement project. Residents interviewed confirm the reason for and benefits of the extra fluid round. This is an area of continuous improvement.</p>

Finding:

Surveillance data is analysed with conclusions and recommendations to achieve infection reduction implemented, however the facility has responded to an increase in UTIs identified during routine analyses of quality data, and implemented a quality improvement project that includes all residents and staff. Initial evaluations show improved benefits for residents with a slight decrease in UTIs.

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*